

SOR2 Organization & Program Information

Select the organization/contract for which you are filling this form out.

- ☐ ADDS
- ☐ ASAC
- ☐ CADS
- ☐ CFR
- ☐ Crossroads
- ☐ Heartland
- ☐ HoM
- ☐ Jackson Recovery Area 1
- ☐ Jackson Recovery Area 4
- ☐ NEIMH
- ☐ New Opportunities
- ☐ Pathways
- ☐ Prairie Ridge
- ☐ Prelude
- ☐ SASC
- ☐ SATUCI
- ☐ SIEDA
- ☐ UCS
- ☐ Zion

Select the quarter for which this form is being filled.

- ☐ Quarter 1 (Sept. 30, 2020 - Dec. 31, 2020)
- ☐ Quarter 2 (Jan. 1, 2021 - March 31, 2021)
- ☐ Quarter 3 (April 1, 2021 - June 30, 2021)
- ☐ Quarter 4 (July 1, 2021 - Sept. 29, 2021)

How many SOR2 admissions (completed GPRA intake) did your organization complete this quarter?

Recovery Support Services (RSS)

Select all MAT services that were offered on-site by your organization (not subcontracted to UCS or other OTP) this quarter.

- ☐ MAT Medical Care
- ☐ MAT Medical Evaluation
- ☐ MAT Medication
- ☐ Not applicable

Select all MAT services that were offered by a partnering organization this quarter.

- ☐ MAT Medical Care
- ☐ MAT Medical Evaluation
- ☐ MAT Medication
- ☐ Not applicable

Select all Recovery Support Services (RSS) your clients received from SOR2 in this quarter.

- ☐ Co-Pays
- ☐ Dental Services
- ☐ Drug Testing
- ☐ HIV & Viral Hepatitis Testing
- ☐ Housing Assistance
- ☐ Recovery Calls
- ☐ Recovery Peer Coaching
- ☐ Supplemental Needs- Clothing/Personal Hygiene Products
- ☐ Supplemental Needs- Education
- ☐ Supplemental Needs- Transportation: Bus
- ☐ Supplemental Needs- Transportation: Gas Cards / Cab / Ride Sharing Apps
- ☐ Supplemental Needs- Utility Assistance
- ☐ Supplemental Needs- Wellness

If you did **not** select a RSS in the previous question, explain why that service(s) was not provided to SOR2 clients this quarter.

HIV and Viral Hepatitis Testing

Fill in the number of **rapid HIV tests** provided on-site to SOR2 clients this quarter according to their associated reactivity and confirmatory status. If none, please fill in the number 0.

	Number of Non-reactive Tests	Number of Reactive Tests	Number of Confirmed Tests
Rapid 1-Minute HIV Tests	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rapid 20-Minute HIV Tests	<input type="text"/>	<input type="text"/>	<input type="text"/>

Fill in the number of **conventional HIV tests** provided on-site to SOR2 clients this quarter according to their associated negativity or positivity and associated confirmatory status. If none, please fill in the number 0.

	Negative HIV Tests	Confirmed HIV Tests
Conventional HIV Tests provided	<input type="text"/>	<input type="text"/>

Fill in the number of **HIV testing referrals** provided to SOR2 clients during this quarter.

Fill in the number of **HIV-PrEP referrals** provided to SOR2 clients during this quarter.

Fill in the **number of Rapid HCV Tests provided on-site** according to their reactivity and confirmatory status. If none were provided this quarter, please fill in the number 0.

	Number of Non-reactive Tests	Number of Reactive Tests	Number of Confirmed Tests
Number of Rapid 20 min. HCV Tests	<input type="text"/>	<input type="text"/>	<input type="text"/>

Fill in the **number of Conventional HCV Tests provided on-site** according to their associated negativity or positivity. If none were provided on-site, please write 0.

	Negative Tests	Confirmed Tests
Conventional HCV Tests	<input type="text"/>	<input type="text"/>

Fill in the **number of HCV testing referrals** to SOR2 clients within this quarter. If none, please write 0.

Please fill in the number of **referrals for vaccinations provided for Hepatitis A and B**. If none, please write 0.

	Number of Referrals
Hepatitis A Vaccine Referrals	<input type="text"/>
Hepatitis B Vaccine Referrals	<input type="text"/>

Describe any barriers to the implementation of **HIV & HCV testing**.

Describe any barriers to the implementation of **HIV and viral hepatitis testing and vaccine referrals**.

Naloxone

How many **Naloxone Kits** have you distributed to the following populations within this quarter? If none, please type 0.

	Number of Naloxone Kits
First Responders	<input type="text"/>
Client and Client's family/friends	<input type="text"/>
Community Service Organizations	<input type="text"/>

Number of Naloxone Kits

Other (please describe)

Training

How many trainings did your organization provide on **Opioids and Prescribing Guidelines** within this quarter?

Number of Trainings

Primary Health Care
Providers (physicians,
nurses, PA's, .etc)

Behavioral Health Care
Providers (counselors,
prevention staff, peer
support coaches, etc.)

First Responders

Other (please describe)

To whom have you provided trainings on **MAT** within this quarter, and for how many?
(estimate to the best of your ability)

Number of Trainings

Primary Health Care
Providers (physicians,
nurses, PA's, .etc)

Behavioral Health Care
Providers (counselors,
prevention staff, peer
support coaches, etc.)

First Responders

Other (please describe)

To whom have you provided trainings on **Naloxone/Opioid Poisoning (Overdose) Prevention** within this quarter, and for how many?

Number of Trainings

Number of Trainings

Primary Health Care
Providers (physicians,
nurses, PA's, .etc)

Behavioral Health Care
Providers (counselors,
prevention staff, peer
support coaches, etc.)

First Responders

Other (please describe)

Cultural Competencies

Select all **cultural competency initiatives** your SOR2 program has engaged in during this quarter.

- ☐ Trainings
- ☐ Coordination of Community Events
- ☐ Participation in Workgroups and Community Fora
- ☐ Other (please describe)

DATA Waiver

How many of your organization's practitioners are eligible for a DATA waiver? How many of your organization's eligible practitioners have recieved a DATA waiver? Please indicate the numbers accordingly below:

Number

Number of Pracitioners *Eligible* for DATA
waiver

Number of Eligible Practitioners *with* a
DATA waiver

Confirmation of Completion

I confirm that I will submit a correspondance in IowaGrants stating I have completed the quarterly report.

☐ Yes

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